

MARKET CONDUCT EXAMINATION REPORT
AS OF DECEMBER 31, 2002

United HealthCare Insurance Company
450 Columbus Boulevard, 4NB
Hartford, CT 06103

NAIC Group Code 0707
NAIC Company Code 79413

EXAMINATION PERFORMED BY
DIVISION OF INSURANCE STAFF
COLORADO DEPARTMENT OF REGULATORY AGENCIES
STATE OF COLORADO

**United HealthCare Insurance Company
450 Columbus Boulevard, 4NB
Hartford, CT 06103**

**LIMITED MARKET CONDUCT
EXAMINATION REPORT
as of
December 31, 2002**

**Examination Performed by
Jeffory A. Olson, CIE, AIRC, ALHC
David M. Tucker, AIE, FLMI, ACS
Maggie Caouette
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Kit Tucker**

State Market Conduct Examiners

October 9, 2003

The Honorable Doug Dean
Commissioner of Insurance
State of Colorado
1560 Broadway, Suite 850
Denver, Colorado 80202

Commissioner:

This limited market conduct examination of United HealthCare Insurance Company (the Company) was conducted pursuant to Sections 10-1-203, 10-1-204, 10-2-205(8), and 10-3-1106, Colorado Revised Statutes, which authorizes the Insurance Commissioner to examine insurance companies. We examined the Company's records at its Denver office located at 8051 East Maplewood Avenue, Suite 300, Greenwood Village, Colorado, 80111 and at the Colorado Division of Insurance offices at 1560 Broadway, Denver, Colorado, 80202. The market conduct examination covered the period from January 1, 2002 through December 31, 2002.

The following market conduct examiners respectfully submit the results of the examination.

Jeffory Olson, CIE, AIRC, ALHC

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Maggie Caouette

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**MARKET CONDUCT
EXAMINATION REPORT
OF
UNITED HEALTHCARE INSURANCE COMPANY**

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COMPANY PROFILE

United HealthCare Insurance Company is the primary insurance company within UnitedHealth Group. Subsidiary insurance companies operate as single state marketing arms in Illinois, New York and Ohio. The company represents the merged, former health insurance operation of MetLife and Travelers - known as the MetraHealth Insurance Company – and United Health and Life Insurance Company, the predecessor insurance operations of UnitedHealth Group, as more fully described below.

United HealthCare Insurance Company (“United HealthCare”) was originally incorporated in Illinois as The Travelers Insurance Company of Illinois in 1972. The name was changed to The MetraHealth Insurance Company during 1994, at which time it was also redomesticated to Connecticut.

On January 3, 1995, Travelers and MetLife each contributed assets associated with their group medical insurance and managed care businesses to The MetraHealth Companies, Inc. (the company’s then direct parent) or its subsidiaries. Travelers and MetLife also contributed to MetraHealth all of the capital stock of their wholly owned subsidiaries, including The MetraHealth Insurance Company, constituting their group medical insurance and managed care businesses.

On October 2, 1995, 100% of The MetraHealth Companies Inc. was purchased by United HealthCare Corporation.

In May 1996, the MetraHealth Companies, Inc. and MetraHealth Pharmacy Management, Inc. were merged with and into The MetraHealth Insurance Company with the company as the survivor.

Due to the considered overlap of The MetraHealth Insurance Company’s state licenses with those of United HealthCare’s original insurance subsidiary, United Health and Life Insurance Company, a Minnesota insurance company, the companies were merged effective January 1, 1997. At the same time, the surviving entity, The MetraHealth Insurance Company, was renamed United HealthCare Insurance Company.

United HealthCare is licensed to write life and group accident and health business in the District of Columbia, the U.S. Virgin Islands, Puerto Rico, Guam, and all states except New York.

United HealthCare provides Medicare supplement and other supplemental coverage to members of the AARP, and other senior insureds, administrative services only (ASO) and stop loss coverage to regional and national large employer accounts, and also small case and middle market segments (groups defined by up to 50 and 5,000 employees, respectively). Two thirds of the middle market business and virtually all of the small case segment is insured business.

In March of 2000, United HealthCare Insurance Company’s direct parent, United HealthCare Corporation changed its name to UnitedHealth Group Incorporated (“UnitedHealth Group”).

In June 2000, UnitedHealth Group contributed all the shares of United HealthCare Insurance Company to its wholly owned subsidiary United HealthCare Services, Inc, who in turn contributed all the issued and outstanding shares of United HealthCare Insurance Company to its wholly owned subsidiary, Unimerica, Inc., a Delaware corporation. As of June 30, 2000, United HealthCare Insurance Company became a direct wholly owned subsidiary of Unimerica, Inc.*

In addition to the medical business, United HealthCare is starting to develop and market life, dental, stop loss, vision and other insured and self-insured plans.

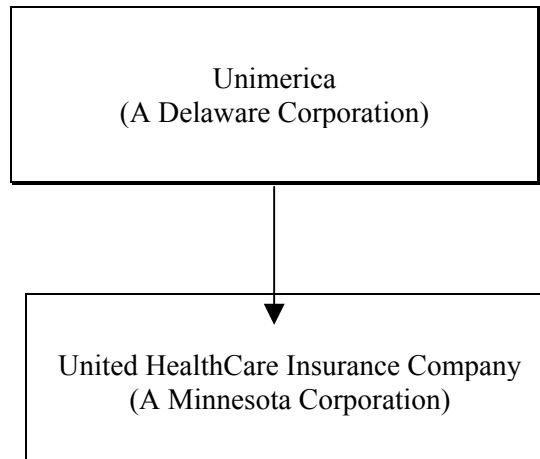
*Except 1/30 of 1 share is owned by affiliate, Uniprise, Inc.

The Company's territory is statewide.

The following organizational chart shows the current structure of United HealthCare Insurance Company.

STRUCTURE AS OF DECEMBER 31, 2002

The following organizational chart depicts the Company's relationship within the corporate structure as of December 31, 2002.



Service Area

United HealthCare is licensed to write life and group accident and health business in the District of Columbia, the U.S. Virgin Islands, Puerto Rico, Guam, and all states except New York.

Enrollment As of 12-31-02: 256,330

Large Groups*: 73,481

Small Groups*: 91,027

Total Written Premium as of 12-31-02: \$ 298,464,098

Small Group Written Premium**: \$ 159,529,167

Large Group Written Premium**: \$ 138,934,931

Market Share (all Colorado Accident and Health Insurance Company's): 16.90%

* Based on "Member Months" reported by the Company for Colorado large and small group members.

** As provided by the Company.

PURPOSE AND SCOPE OF EXAMINATION

State market conduct examiners with the Colorado Division of Insurance (DOI), in accordance with Colorado Insurance Law, Sections 10-1-201, 10-1-203, and 10-1-204, C.R.S., which empowers the Commissioner to require any company, entity, or new applicant to be examined, reviewed certain business practices of United HealthCare Insurance Company. The findings in this report, including all work products developed in producing it, are the sole property of the Colorado Division of Insurance.

The purpose of the limited examination was to determine the Company's compliance with Colorado insurance law and with generally accepted operating principles related to Large and Small Group health insurance. Examination information contained in this report should serve only these purposes. The conclusions and findings of this examination are public record. The preceding statements are not intended to limit or restrict the distribution of this report.

Examiners conducted the examination in accordance with procedures developed by the Colorado Division of Insurance, based on model procedures developed by the National Association of Insurance Commissioners. They relied primarily on records and materials maintained by the Company. The limited market conduct examination covered the period from January 1, 2002, through December 31, 2002.

The examination included review of the following:

Contract Forms; and
New Business Applications.

The final exam report is a report written by exception. References to additional practices, procedures, or files that did not contain improprieties, were omitted. Based on review of these areas, comment forms were prepared for the Company identifying any concerns and/or discrepancies. The comment forms contain a section that permits the Company to submit a written response to the examiners' comments.

For the period under examination, the examiners included statutory citations and regulatory references related to small and large group health insurance reform laws. Examination findings may result in administrative action by the Division of Insurance. Examiners may not have discovered all unacceptable or non-complying practices of the Company. Failure to identify specific Company practices does not constitute acceptance of such practices. This report should not be construed to either endorse or discredit any health insurance company.

An error tolerance level of plus or minus ten dollars (\$10.00) was allowed in most cases where monetary values were involved. However, in cases where monetary values were generated by computer or other systemic methodology, a zero dollar (\$0) tolerance level was applied in order to identify possible system errors. Additionally, a zero dollar (\$0) tolerance level was applied in instances where there appeared to be a consistent pattern of deviation from the Company's established policies, procedures, rules and/or guidelines.

When sampling was involved, a minimum error tolerance level of five percent (5%) was established to determine reportable exceptions. However, if an issue appeared to be systemic, or when due to the sampling process it was not feasible to establish an exception percentage, a minimum error tolerance percentage was not utilized. Also, if more than one sample was reviewed in a particular area of the examination (e.g. timeliness of claims payment), and if one or more of the samples yielded an exception rate of five percent (5%) or more, the results of any other samples with exception percentages less than five percent (5%) were also included.

EXAMINERS' METHODOLOGY

The examiners reviewed the Company's business practices to determine compliance with Colorado insurance laws and regulations. For this examination, special emphasis was given to small group reform, and the laws and regulations as shown in Exhibit 1.

At the beginning of the examination, the examiners met with the Company examination coordinator to discuss the examination process. One of the topics discussed was that although United HealthCare Insurance Company and United HealthCare of Colorado, Inc. are separate companies, there are many policies, procedures and forms that are common to both companies. Therefore, it was agreed that in those cases where it appeared that a comment form may be applicable to both companies, the examiners would include an option for the Company to "deem" the findings to be applicable to both companies, even though the actual findings may have been identified in only one of the companies.

Exhibit 1

Law/Regulation	Concerning
Section 10-1-101-10-1-130	General Provisions
Section 10-3-1101-10-3-1104	Unfair Competition - Deceptive Practices
Section 10-8-601-10-8-605	Small Employer Health Insurance Availability Program Act
Section 10-16-101-10-16-121	Colorado Health Care Coverage Act: Part I: Short Title - Definitions - General Provisions
Section 10-16-201-10-16-219	Sickness and Accident Insurance
Section 10-16-701-10-16-708	Consumer Protection Standards Act for the Operation of Managed Care Plans
Regulation 1-1-7	Market Conduct Record Retention
Regulation 1-1-8	Penalties And Timelines Concerning Division Inquiries And Document Requests
Regulation 4-2-5	Hospital Definition
Regulation 4-2-8	Concerning Required Health Insurance Benefits for Home Health Services and Hospice Care.
Regulation 4-2-15	Required Provisions in Carrier Contracts with Providers and Intermediaries Negotiating on Behalf of Providers
Regulation 4-2-16	Women's Access to Obstetricians and Gynecologists under Managed Care Plans
Regulation 4-2-18	Concerning the Method of Crediting and Certifying Creditable Coverage for Pre-existing Conditions
Regulation 4-6-5, (Amended)	Implementation of Basic and Standard Health Benefit Plans
Regulation 4-6-8	Concerning Small Employer Health Plans
Regulation 4-6-9	Conversion Coverage

Audits and Examinations

The Company was the subject of a previous market conduct exam in 1998 and 1999, which covered the period January 1, 1997 through January 31, 1998. The Company also underwent a financial audit by the Colorado Division of Insurance in 1998 and 1999, which covered the period of January 1, 1994 through December 31, 1998.

Contract Forms

The examiners reviewed the following forms:

- The Company's Basic and Standard PPO and Indemnity Plans, Co-payment Schedules, Certificates of Coverage and Schedule of Benefits;
- The Company's most commonly sold PPO group contracts marketed to small employers and business groups of one;
- The Company's PPO conversion contracts, application form, definitions, eligibility, and termination provisions; and
- The Company's group and employee PPO applications/enrollment forms and supporting documents.

These plans were issued and/or certified with the Colorado Division of Insurance (DOI) between January 1, 2002 and December 31, 2002.

Applications

For the period January 1, 2002 through December 31, 2002, the examiners reviewed fifty (50) small group new application files which were systematically selected from an initial population of 4,892.

EXAMINATION REPORT SUMMARY

The examination resulted in a total of twelve (12) findings in which the Company did not appear to be in compliance with Colorado Statutes and Regulations. The following is a summary of the examiners' findings and recommendations.

Contract Forms: The examiners identified eight (8) areas of concern in their review of the Company's contract forms (including evidence of coverage forms, employer/employee applications, group service contracts, and any riders).

1. Failure of the Company's forms to provide coverage for dental care resulting from accidents in all instances as required by law.
2. Failure of the Company's forms to provide a complete and accurate description of the required Hospice Care benefits.
3. Failure of the Company's forms to provide durable medical equipment benefits in accordance with Colorado insurance law.
4. Failure of the Company's forms, in some instances, to limit the look-back period for medical information to five (5) years.
5. Failure of the Company's forms, in some instances, to allow for otherwise eligible employees to enroll in continuation coverage. *(This was prior issue E15 in the findings of the 1999 final examination report).*
6. Failure of the Company's policy forms to provide accurate information concerning premium rate setting.
7. Failure of the Company's forms to define congenital anomaly in a manner consistent with benefit coverages mandated by Colorado insurance law.
8. Failure of the Company's forms to provide correct information regarding changes to premium rates.

Applications: The examiners identified four (4) areas of concern in their review of small group contracts issued between January 1, 2002 and December 31, 2002.

1. Failure, in some instances, to secure and maintain signed applications or waivers of coverage for eligible employees and/or their dependents.
2. Failure, in some instances, to include the required Basic and Standard Health Benefit Plan disclosure in small group application materials.
3. Failure to obtain the required employer provided listing of eligible dependents.
4. Failure, in some instances, to include the small group disclosure requirements in new application materials. *(This was prior issue G5 in the findings of the 1999 final examination report.)*

A copy of the Company's response, if applicable, can be obtained by contacting the Company or the Colorado Division of Insurance.

Results of previous Market Conduct Exams are available on the Colorado Division of Insurance website at www.dora.state.co.us/insurance or by contacting the Colorado Division of Insurance.

MARKET CONDUCT EXAMINATION REPORT

FACTUAL FINDINGS

UNITED HEALTHCARE INSURANCE COMPANY

**UNDERWRITING
CONTRACT FORM
FINDINGS**

Issue E1: Failure of the Company's forms to provide coverage for dental care resulting from accidents in all instances required by law.

Regulation 4-6-5, amended effective January 1, 2002, Implementation of basic and standard health benefit plans, promulgated pursuant to Sections 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states:

III. Rules

- A. The form and content of the basic and standard health benefit plans, as appended to this regulation, shall constitute the basic and standard health benefit plans required for use in Colorado's small employer market pursuant to Section 10-16-105(7.3), C.R.S., and for use as conversion coverage pursuant to Section 10-16-108, C.R.S.

Basic and Standard Health Benefit Plan Policy Requirements for the State of Colorado

- I. The basic health benefit plan for an indemnity, preferred provider, and health maintenance organization (HMO) plan shall include the specific benefits and coverages outlined in the attached table labeled "Basic Health Benefit Plan."
- II. The standard health benefit plan for an indemnity, preferred provider, and HMO plan shall include the specific benefits and coverages outlined in the attached table labeled "Standard Health Benefit Plan."

35. What Treatments and Conditions are Excluded under this Policy?

Standard exclusions, including benefits covered by a no-fault auto policy or employers liability laws; care that is not medically necessary; cosmetic care; custodial care; *dental care except for accidents* [emphasis added] and anesthesia for dependent children as required by law...

It appears that the Company is not in compliance with the requirements of Colorado insurance law in that benefits for dental care following an accidental injury are more restrictive than required by law. The Company's 2002 Basic and Standard Health Benefit Plan certificate of coverage forms limit benefits to treatment of a sound, natural tooth that is certified by the dentist or physician as a virgin or unrestored tooth.

2002 Basic and Standard Health Benefit Plan Certificate of Coverage, states:

4. Dental Services – Accident only

Benefits are available only for treatment of a sound, natural tooth. The Physician or dentist must certify that the injured tooth was:

- *A virgin or unrestored tooth* [emphasis added], or

- A tooth that has no decay, no filling on more than two surfaces, no gum disease associated with bone loss, no root canal therapy, is not a dental implant and functions normally in chewing and speech.

<u>Forms</u>	<u>Date</u>
BASPPO.01.CO	1/1/2002
PPOCERT.01.CO	10/1/2001
STDPPPO.01.CO	1/1/2002
TECOBAS(99)	3/1/2001
TECOSTD(99)	3/1/2001

Recommendation No. 1:

Within thirty (30) days the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-6-5. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all of its affected forms to remove the restrictions on dental coverage as the result of accidents to ensure compliance with Colorado insurance law.

Issue E2: Failure of the Company's forms to provide a complete and accurate description of the required Hospice Care benefits.

Regulation 4-2-8, amended effective February 1, 2001, Concerning Required Health Insurance Benefits For Home Health Services And Hospice Care, promulgated pursuant to 10-1-109 and 10-16-104(8)(d), C.R.S., states:

Section 2. Purpose

The purpose of this regulation is to establish requirements for standard policy provisions, which *shall state clearly and completely the criteria for and extent of coverage for home health services and hospice care ...* [Emphasis added.]

Section 5. Requirements for Hospice Care

C. Benefits for Hospice Care Services.

- (3) The policy offering shall include the following benefits, subject to the policy's deductible, coinsurance and stoploss provisions, which are exclusive of and shall not be included in the dollar limitation for hospice care benefits as specified in (2) above:
 - (a) Bereavement support services for the family of the deceased person during the *twelve month period following death* [emphasis added], and in no event shall this maximum benefit be less than \$1150.
 - (b) Short-term general inpatient (acute) hospice care or continuous home care which may be required during a period of crisis, for pain control or symptom management and shall be paid consistent with any other sickness or illness (i.e., not included in the per diem limitation specified in (2) above). Such care shall require prior authorization of the interdisciplinary team and may, except for emergencies, weekends or holidays, require prior authorization by the insurer, provided, however, that the insurer may not require prior authorization when the transfer to the higher level of care was necessary during the insurer's non-business hours if the hospice seeks the authorization during the insurer's first business day;
 - (c) *Medical supplies;*
 - (d) *Drugs and biologicals;*

- (e) *Prosthesis and orthopedic appliances;*
- (f) *Oxygen and respiratory supplies;*
- (g) *Diagnostic testing;*
- (h) *Rental or purchase of durable equipment;*
- (i) *Transportation;*
- (j) *Physicians services;*
- (k) *Therapies including physical, occupational and speech; and*
- (l) *Nutritional counseling by a nutritionist or dietitian.* [Emphases added.]

Regulation 4-6-5, amended effective January 1, 2002, Implementation of Basic and Standard Health Benefit Plans, promulgated pursuant to Sections 10-1-109, C.R.S., 10-16-105(7.2), C.R.S., and 10-16-108.5(8), C.R.S., states:

III. Rules

- A. The form and content of the basic and standard health benefit plans, as appended to this regulation, shall constitute the basic and standard health benefit plans required for use in Colorado's small employer market pursuant to Section 10-16-105(7.3), C.R.S., and for use as conversion coverage pursuant to Section 10-16-108, C.R.S.

BASIC AND STANDARD HEALTH BENEFIT PLAN
POLICY REQUIREMENTS FOR THE STATE OF COLORADO

Colorado Division of Insurance
January 1, 2002

- I. The basic health benefit plan for an indemnity, preferred provider, and health maintenance organization (HMO) plan shall include the specific benefits and coverages outlined in the attached table labeled "Basic Health Benefit Plan."
- II. The standard health benefit plan for an indemnity, preferred provider, and HMO plan shall include the specific benefits and coverages outlined in the attached table labeled "Standard health Benefit Plan."

	BASIC INDEMNITY PLAN
26. HOSPICE CARE ^{22a.}	50% per diem

	STANDARD INDEMNITY PLAN
26. HOSPICE CARE ^{22a.}	70% per diem

	BASIC PPO PLAN	BASIC PPO PLAN
	IN-NETWORK	OUT-OF-NETWORK ^{1a}
26. HOSPICE CARE ^{22a.}	70% per diem	50% per diem

	STANDARD PPO PLAN	STANDARD PPO PLAN
	IN-NETWORK	OUT-OF-NETWORK ^{1a}
26. HOSPICE CARE ^{22a.}	80% per diem	50% per diem

- 1a. Out-of-network cost sharing (deductible, coinsurance, and out-of-pocket maximums) levels apply **ONLY IF** plan has network providers for the covered benefit and insured goes out of the network. Otherwise, in-network-levels apply.
- 22a. Although the number of days for this benefit is not limited, ancillary services, such as bereavement, shall be limited consistent with Regulation 4-2-8.

It appears that the Company's forms are not in compliance with Colorado insurance law in that they do not provide a complete and accurate description of Hospice Care benefits. The Company's 2002 Basic and Standard Health Benefit Plan certificate of coverage forms do not indicate that the following items are covered:

- Medical supplies;
- Drugs and biologicals;
- Prosthesis and orthopedic appliances;
- Oxygen and respiratory supplies;
- Diagnostic testing;
- Transportation;
- Physical, occupational and speech therapies;
- Nutritional counseling;
- Rental or purchase of durable equipment; and
- Physician services.

Additionally, the limitation of bereavement support services to the three month period following death appears to be more restrictive than that of Colorado insurance law.

The Company's 2002 Basic and Standard Health Benefit Plan Certificate of Coverage, states:

Hospice Care

State Mandate

Hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social and spiritual care for the terminally ill person, and short-term grief counseling for immediate family members, the Covered Person's primary caregiver and for individuals with significant personal ties to the Covered Person. Benefits are available when hospice care is received from a hospice agency that is licensed and regulated by the Colorado Department of Public Health and Environment. Hospice care includes intermittent non-routine inpatient respite care on a short-term basis.

Benefits are limited to three benefit periods of three months per benefit period during the entire period of time you are covered under the Policy. *Benefits for bereavement support services are limited to \$1,150 during the three month period following death.* [Emphasis added.]

Please contact us for more information regarding our guidelines for hospice care. You can contact us at the telephone number on your ID card.

<u>Forms</u>	<u>Date</u>
BASPPPO.01.CO	1/1/2002
PPOCERT.01.CO	10/1/2001
STDPPPO.01.CO	1/1/2002
TECOBAS(99)	3/1/2001
TECOSTD(99)	3/1/2001

Recommendation No. 2:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulations 4-2-8 and 4-6-5. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all affected forms to reflect the correct Hospice Care benefits as mandated by Colorado insurance law.

Issue E3: Failure of the Company's forms to provide durable medical equipment benefits in accordance with Colorado insurance law.

Section 10-16-104, C.R.S., Mandatory coverage provisions, states:

14. Prosthetic devices.

- (d) Covered benefits are limited to the most appropriate model that adequately meets the medical needs of the patient as determined by the insured's treating physician.
- (e) Repairs and replacements of prosthetic devices are also covered, subject to copayments and deductibles, unless necessitated by misuse or loss.
- (f) A carrier may require that, if coverage is provided through a managed care plan, the benefits mandated pursuant to this subsection (14) shall be covered benefits only if the prosthetic devices are provided by a vendor and prosthetic services are rendered by a provider who contracts with or is designated by the carrier, to the extent that a carrier provides in-network and out-of-network services, the coverage for the prosthetic device shall be offered no less extensively.

Regulation 4-6-5, amended effective January 1, 2002, Implementation of basic and standard health benefit plans, promulgated pursuant to Sections 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states:

III. Rules

- A. The form and content of the basic and standard health benefit plans, as appended to this regulation, shall constitute the basic and standard health benefit plans required for use in Colorado's small employer market pursuant to Section 10-16-105(7.3), C.R.S., and for use as conversion coverage pursuant to Section 10-16-108, C.R.S.

**BASIC AND STANDARD HEALTH BENEFIT PLAN
POLICY REQUIREMENTS FOR THE STATE OF COLORADO**

Colorado Division of Insurance
January 1, 2002

- I. The basic health benefit plan for an indemnity, preferred provider, and health maintenance organization (HMO) plan shall include the specific benefits and coverages outlined in the attached table labeled "Basic Health Benefit Plan."
- III. The standard health benefit plan for an indemnity, preferred provider, and HMO plan shall include the specific benefits and coverages outlined in the attached table labeled "Standard Health Benefit Plan."

	BASIC PPO PLAN	BASIC PPO PLAN	BASIC INDEMNITY PLAN
	IN-NETWORK	OUT-OF-NETWORK ^{1a}	
22. DURABLE MEDICAL EQUIPMENT ²¹	50% up to maximum \$800/year paid by plan	50% up to maximum \$800/year paid by plan	50% up to maximum \$800/year paid by plan

	STANDARD PPO PLAN	STANDARD PPO PLAN	STANDARD INDEMNITY PLAN
	IN-NETWORK	OUT-OF-NETWORK ^{1a}	
22. DURABLE MEDICAL EQUIPMENT ²¹	50% up to maximum \$800/year paid by plan	50% up to maximum \$800/year paid by plan	50% up to maximum \$800/year paid by plan

1a. Out-of-network cost sharing (deductible, coinsurance, and out-of-pocket maximums) levels apply **ONLY IF** plan has network providers for the covered benefit and insured goes out of the network. Otherwise, in-network-levels apply.

21. Coverage for lesser of purchase or rental price for medically necessary durable medical equipment. DME includes, but is not limited to, home-administered oxygen, reusable equipment for the treatment of diabetes, *and prostheses. Although the cost of prosthetic devices applies to the annual DME cap, benefits for prosthetic devices for arms or legs (or any part thereof) themselves are not subject to this limitation. The benefit level for prosthetic devices for arms or legs or parts thereof shall be as required by 10-16-104(14), C.R.S. Repair or replacement of defective equipment is covered at no additional charge; repair and replacement needed because of normal usage is covered up to the benefit cap; and repair and replacement needed due to misuse/abuse by the insured is **not** covered.* [Emphases added.]

It appears that the Company is not in compliance with the requirements of Colorado insurance law in that benefits for durable medical equipment are more restrictive than required by law. The Company's 2002 Basic and Standard Health Benefit Plan certificate of coverage forms fail to include the specific benefits and coverages as required. Additionally, benefits for the purchase, repair or replacement for a single purchase item are limited to once every three years. Colorado insurance law requires coverage for necessary replacement of prosthetic devices without a specific time restriction except if the replacement is needed due to misuse or abuse by the insured.

2002 Basic and Standard Health Benefit Plan Certificate of Coverage, states:

6. Durable Medical Equipment

Examples of Durable Medical Equipment include:

- Equipment to assist mobility, such as a standard wheelchair.
- A standard Hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, and connectors.)
- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an Injured body part are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are excluded from coverage. Dental braces are also excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and person comfort items are excluded from coverage.)

We provide Benefits only for a single purchase (including repair/replacement) of a type of Durable Medical Equipment once every three calendar years. [Emphasis added.]

20. Prosthetic Devices

Prosthetic devices that replace a limb or body part including:

- Artificial limbs.
- Artificial eyes.
- Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the most cost-effective prosthetic device.

The prosthetic device must be ordered or provided by, or under the direction of a Physician. *Benefits for prosthetic devices are limited to a single purchase of each type of prosthetic device every three calendar years. [Emphasis added.]*

Forms

Date

BASPPO.01.CO	1/1/2002
PPOCERT.01.CO	10/1/2001
STDPPPO.01.CO	1/1/2002
TECOBAS(99)	3/1/2001
TECOSTD(99)	3/1/2001

Recommendation No. 3:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-104, C.R.S. and Amended Regulation 4-6-5. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all affected forms to reflect the correct durable medical equipment benefits as required by Colorado insurance law.

Issue E4: Failure of the Company's forms, in some instances, to limit the look-back period for medical information to five (5) years.

Section 10-16-105, C.R.S., Small group sickness and accident insurance – guaranteed issue – mandated provisions for basic and standard health benefit plans, states:

- (7) An individual, corporation, association, partnership, or any other entity engaged in the health insurance business subject to provisions of this section *shall not request or require from a small group applying for coverage, or from an individual in a small group applying for coverage, medical information going back more than five years from the date of application* [emphasis added]. Medical information which is more than five years old on any of the enrollee members of a small group shall not be used by the insurer in underwriting or setting premiums for the group. Nothing in this subsection (7) shall preclude a small group health insurer subject to the provisions of part 2 of this article from asking about the current health status of any of the individuals in a group applying for coverage or using such information on current health status to underwrite or set premiums for the group.

It appears that the Company's forms are not in compliance with Colorado insurance law in that individual enrollees of small employer groups are required to authorize the Company to obtain medical information without limiting the authorization to the maximum five (5) year look-back period limitation.

The Company's "Employee Enrollment Form", under the "Statement of affirmation and authorization to obtain and disclose information in connection with eligibility for medical coverage" section contained on the back of the application states the following:

"I (we) authorize all providers of health services or supplies and any of their representatives to give the following to the HMO/insurance company(ies): any available information about the medical history, condition or treatment of any person named in this request. I (we) authorize the HMO/insurance company(ies) to use this information to determine eligibility for medical coverage and eligibility for benefits under an existing policy."

Form

Date

380-1474 Employee Enrollment Form

9/02

Recommendation No. 4:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-105, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its forms to limit the look-back period to five (5) years as required by Colorado insurance law.

Issue E5: Failure of the Company's forms, in some instances, to allow for otherwise eligible employees to enroll in continuation coverage. *(This was prior issue E15 in the findings of the 1999 final examination report).*

Section 10-16-108, C.R.S., Conversion and continuation privileges, states:

- (b) Every group sickness and accident insurance policy included within the provisions of section 10-16-214(1) shall contain a provision which permits every covered employee whose employment is terminated, if the policy remains in force for active employees of the employer, to elect to continue the coverage for himself and his dependents. Such provision shall conform to the requirements, where applicable, of subparagraph (XVII) of paragraph (d) and paragraphs (e) and (f) of this subsection (1).
- (d)(XIX) The employer shall not be required to *offer* [emphasis added] continuation of coverage of any person if such person is covered by medicare, Title XVIII of the federal "Social Security Act," or medicaid, Title XIX of the federal "Social Security Act."
- (e) (I) Upon the termination of employment of an eligible employee, *the death of any such employee, or the change in marital status of any such employee, the employee or dependent has the right to continue the coverage for a period of eighteen months* after loss of coverage or until such employee or dependent becomes eligible for other *group coverage*. However, should new coverage exclude a condition covered under the continued plan, coverage under the prior employer's plan may be continued for the excluded condition only for the eighteen months or until the new plan covers the condition, whichever occurs first. [Emphases added.]

It appears that the Company is not in compliance with the requirements of Colorado insurance law in that eligibility for continuation coverage is more restrictive than allowed by law. Continuation coverage cannot be denied because an individual is *eligible* for Medicare or Medicaid. Coverage may only be denied if the individual is *covered* under Medicare or Medicaid. In addition, Continuation Coverage cannot be terminated solely because the individual has moved outside the service area. Members are eligible if they either live or work in the service area.

Certificate of Coverage, states:

Qualifying Events for Continuation Coverage under State Law

To qualify for continuation coverage under state law, the Covered Person must meet the criteria below: ...

- The Covered Person is not *eligible* for Medicare or Medicaid.
- The Covered Person is not enrolled in Medicare.

Terminating Events for Continuation Coverage under State Law

Continuation coverage under the Policy will end on the earliest of the following dates: ...

- The date you move outside the Service Area.

<u>Forms</u>	<u>Date</u>
BASPPO.01.CO	1/1/2002
PPOCERT.01.CO	10/1/2001
STDPPPO.01.CO	1/1/2002
TECOBAS(99)	3/1/2001
TECOSTD(99)	3/1/2001

Recommendation No. 5:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-108, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its forms to allow for qualified individuals to enroll in continuation coverage as required by Colorado insurance law.

In the Market Conduct examination for the period January 1, 1997 through January 31, 1998, the Company was cited for failure to offer state continuation to, and/or to continue state continuation coverage of, some eligible Members. The violation resulted in Recommendation #15, that the Company revise its forms to omit the exclusion of Medicare eligibles. Failure to comply with the previous recommendation and order of the commissioner may constitute a violation of Section 10-1-205, C.R.S.

Issue E6: Failure of the Company's policy forms to provide accurate information concerning premium rate setting.

Regulation 4-6-7, amended effective January 1, 2001, Concerning Premium Rate Setting for Small Group Health Plans, promulgated pursuant to Sections 10-1-109(1), 10-16-105(6.5), 10-16-105(7.2), 10-16-105(8)(f), and 10-16-109, states:

Section 5. Premium Rate Setting

A. Calculating Premium Rates Adjusted for Case Characteristics

- (1) Index Rate – Each carrier offering a health benefit plan to groups in Colorado shall develop *a single index rate for all small group plans it offers. This single index rate is identical to a community rate for the company's universe of small group plans offered for new issue or renewal.* It should be calculated using the experience *for all small group plans.* The premium rate charged during a rating period, *applicable to all small employers, shall be based upon this index rate, adjusted for case characteristics and coverage as allowed in this Section 5.*
- (2) Plan Design Adjustment – The Index Rate may be adjusted to reflect differences attributable to different plan designs. If the small employer carrier elects to make this adjustment, the small employer carrier should calculate a rate adjustment factor for each small group plan design. *Differences in the rates for different benefit plans, for persons with the same case characteristics, shall be attributable to plan design only and shall not reflect actual or expected differences in costs or utilization attributable to the health status of those enrolling under different plans...*[Emphases added.]

C. Rating Period

The rating period for all small group health plans *shall be twelve (12) months* [emphasis added] unless:

- (1) A small employer carrier specifies in its rate filing a different rating period, which shall be *the same for all its health benefit plans issued or renewed in the same calendar month* [emphasis added], pursuant to Section 10-16-105(8)(c)(II), C.R.S.; and
- (2) The small employer carrier clearly discloses in all its small employer solicitation and sales materials exactly what the different rating period is, pursuant to Section 10-16-105(5)(b), C.R.S.

It appears that the Company is not in compliance with the requirements of Colorado insurance law in that its Group Policy for the PPO and Indemnity Health Benefit Plans contains references to changing the schedule for rates that are outside the provisions allowed for premium adjustments. Additionally, the language in the Group Policy indicates that health status is a factor used to set premiums for the group, which is prohibited by law.

Group Policy, Exhibit 1, states:

4. Premiums

We reserve the right to change the schedule of rates for Premiums, after a 31-day prior written notice [¹ on the first anniversary of the effective date of this Policy specified in the application or on any month due date thereafter, or *on any date the provisions of this Policy are amended. We also reserve the right to change the schedule of rates for Premiums, retroactive to the effective date, if a material misrepresentation relating to health status has resulted in a lower schedule of rates.*][¹at any time.] [Emphasis added.]

Forms

Date

IPolicySTDBAS01.CO

1/1/2002

Recommendation No. 6:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-6-7. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all affected forms to provide correct information concerning changes in rates in accordance with the requirements of Colorado insurance law.

Issue E7: Failure of the Company's forms to provide coverage for congenital defects and birth abnormalities as mandated by Colorado insurance law.

Section 10-16-104 (1.7) C.R.S., Therapies for congenital defects and birth abnormalities, states:

- (a) After the first thirty-one days of life, policy limitations and exclusions that are generally applicable under the policy may apply; except that all individual and group health benefit plans shall provide *medically necessary physical, occupational, and speech therapy for the care and treatment of congenital defects and birth abnormalities for covered children up to five years of age.* [Emphasis added.]

It appears that the Company is not in compliance with the requirements of Colorado insurance law in that its Certificates of Coverage define a Congenital Anomaly as a physical developmental defect that is present at birth *and is identified within the first twelve months of birth.* [Emphasis added. This definition creates the potential to exclude coverage for these conditions during the first five years of life, in that a congenital defect or birth abnormality may have been present at birth, but may not have been identified within the first twelve months of life.

Certificate of Coverage, states:

Congenital Anomaly – a physical developmental defect that is present at birth, *and is identified within the first twelve months of birth.* [Emphasis added.]

<u>Forms</u>	<u>Date</u>
BASPPO.01.CO	1/1/2002
PPOCERT.01.CO	10/1/2001
STDPPPO.01.CO	1/1/2002
TECOBAS(99)	3/1/2001
TECOSTD(99)	3/1/2001

Recommendation No. 7:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all affected forms to eliminate the requirement that congenital anomalies must be identified within the first twelve months of life, to ensure compliance with Colorado insurance law.

Issue E8: Failure of the Company's forms to provide correct information regarding changes to premium rates.

Section 10-16-105(8), C.R.S., Small group sickness and accident insurance- guaranteed issue – mandated provisions for basic and standard health benefit plans, states:

- (a) (I) The premium rate charged during a rating period to small employers shall be based on a single, same index rate, applicable to all small employers, adjusted for case characteristics and coverage, ...

Regulation 4-6-7, amended effective January 1, 2001, Concerning Premium Rate Setting for Small Group Health Plans, promulgated pursuant to Sections 10-1-109(1), 10-16-105(6.5), 10-16-105(7.2), 10-16-105(8)(f), and 10-16-109, states:

Section 5. Premium Rate Setting

- B. Allowable Rate Adjustment Factor for Small Group Plans Issued or Renewed on or After January 1, 1998

The rate adjustment factor for small group plans issued or renewed on or after January 1, 1998, shall be 1.0. This means the case characteristics-adjusted index rate calculation pursuant to subsection A of Section 5 of this regulation *may not be further adjusted using any other factors* ...[Emphasis added.]

- D. Administrative and Other Fees

- (1) Carriers and producers *shall not charge any additional fees whatsoever in addition to premium. Separate administrative, processing, renewal, enrollment, and other special charges are prohibited. Such charges must be built into the index rate and are not an allowable rate adjustment factor.* ...[Emphases added.]

It appears that the Company is not in compliance with the requirements of Colorado insurance law in that its Group Policies indicate that rates may be adjusted for additional charges that are not allowable under Colorado law. Carriers may not charge any additional fees in addition to premium except for amounts necessary to recoup assessments paid for CoverColorado. In addition, any change in the Company's small group rates must be filed with the Division of Insurance before the new rates can be used, regardless of the reason(s) that necessitated the change.

Group Policy, states:

3.3 Adjustments to the Policy Charge

... If *premium taxes*, guarantee or uninsured fund assessments, or *other governmental charges* relating to or calculated in regard to Premium are either imposed or increased, *those charges shall be automatically added to the Premium*. In addition, any change in law or regulation that significantly affects our cost of operation shall result in an increase in Premium, in an amount we determine. [Emphases added.]

Forms

Date

IpolicySTDBAS.01.CO

1/1/2002

Recommendation No. 8:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-105, C.R.S., and amended Regulation 4-6-7. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all affected forms to reflect correct information regarding premium rate changes to ensure compliance with Colorado insurance law.

**UNDERWRITING
APPLICATIONS
FINDINGS**

Issue G1: Failure, in some instances, to secure and maintain signed applications or waivers of coverage for eligible employees and/or their dependents.

Regulation 4-6-5, amended effective January 1, 2002, Implementation of Basic and Standard Health Benefit Plans, Rules, promulgated pursuant to Sections 10-1-109, 10-16-105(7.2), and 10-16-108.5(8), C.R.S., states:

Basic and Standard Health Benefit Plan Policy Requirements for the State of Colorado

V. All basic and standard health benefit plans shall also comply with the following requirements:

F. Enrollment – *To enroll an employee and dependents, the carrier shall require that:*

1. Employers:

- a. Submit a written request for coverage;
- b. Provide information necessary to determine eligibility; and
- c. Agree to pay the required premium.

2. *Eligible employees, on a form made available by the employer:*

- a. *Submit a written request for coverage for himself/herself and any dependents; and*
- b. Provide information necessary to determine eligibility, if it is required. [Emphases added.]

Regulation 4-6-8(5)(B), amended effective November 1, 1997, Concerning Small Employer Health Plans, Issuance of Coverage, Determining Who is an Eligible Employee, Dependent, promulgated under authority of Sections 10-1-109(1), 10-8-601.5(1)(a)(IV), (1)(c)(I) and (3), 10-16-105(5), 10-16-108.5(8), 10-16-109, 10-16-214(1)(d), and 10-16-708, C.R.S., states:

(4) *A small employer carrier shall secure a waiver with respect to each eligible employee and each dependent of such an employee (or each employer-determined eligible employee and their dependents if this is different than the list of eligible employees) who declines an offer of coverage under a health benefit plan provided to a small employer. The waiver shall be signed by the eligible employee (on behalf of such employee or the dependent of such employee) and shall certify that the individual who declined coverage was informed of the availability of coverage under the health benefit plan. The waiver form shall require that the reason for declining coverage (e.g., covered under spouse's plan, can't afford coverage, etc.) be stated on the form and shall include a written warning of the penalties imposed on late enrollees. Waivers shall be maintained by the small employer carrier for all active employees. [Emphases added.]*

Small Group Application Sample

Population	Sample Size	Number of Exceptions	Percentage to Sample
4,892	50	31	62%

It appears that the Company is not in compliance with the requirements of Colorado insurance law in that, in some instances, it did not obtain either a completed application or a waiver of coverage for all eligible employees and their dependents of small employers who purchased health benefit plans issued by United HealthCare Insurance Company.

The examiners reviewed a systematically selected sample of fifty (50) new small group application files from a total population of 4,892 new groups sold during the examination period of January 1 to December 31, 2002. Of the fifty (50) files reviewed, twenty-eight (28) files did not contain a total of sixty-nine (69) required waivers of coverage for eligible employees and/or their dependents.

Additionally, three (3) files did not contain either a completed application or a waiver of coverage from employees who were in the waiting period at the time the group coverage was initially effective, and who subsequently became eligible for coverage.

Recommendation No. 9:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulations 4-6-5 and 4-6-8. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its procedures to ensure that all required waivers of coverage and/or applications are secured and maintained upon the initial issue of the small employer group or subsequent to an employee in the waiting period at initial application becoming an eligible employee as required by Colorado insurance law.

Issue G2: Failure, in some instances, to include the required Basic and Standard Health Benefit Plan disclosure in small group application materials.

Regulation 4-6-5(III)(E), amended effective January 1, 2002, Implementation of Basic and Standard Health Benefit Plans, Rules, promulgated pursuant to Sections 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states:

The following disclosure statement, prominently displayed in a clear and conspicuous manner for printed materials, electronic or internet-based communications shall appear on all small employer marketing materials (except Colorado Comprehensive Health Benefit Plan Description Form pursuant to Colorado Division of Insurance Regulation 4-2-20), *small employer application forms*, [emphasis added] and small employer renewal notices, and on all written refusals to insure which are related to health coverage for a business group of one.

“COLORADO INSURANCE LAW REQUIRES ALL CARRIERS IN THE SMALL GROUP MARKET TO ISSUE ANY HEALTH BENEFIT PLAN IT MARKETS IN COLORADO TO SMALL EMPLOYERS OF 2 – 50 EMPLOYEES, INCLUDING A BASIC OR STANDARD HEALTH BENEFIT PLAN, UPON THE REQUEST OF A SMALL EMPLOYER TO THE ENTIRE SMALL GROUP, REGARDLESS OF THE HEALTH STATUS OF ANY OF THE INDIVIDUALS IN THE GROUP. BUSINESS GROUPS OF ONE CANNOT BE REJECTED UNDER A BASIC OR STANDARD HEALTH BENEFIT PLAN DURING OPEN ENROLLMENT PERIODS AS SPECIFIED BY LAW.”

Small Group Application Sample			
Population	Sample Size	Number of Exceptions	Percentage to Sample
4,892	50	9	18%

The examiners reviewed a systematically selected sample of fifty (50) files from a population of 4,892 representing new small group applications for coverage during the period January 1 through December 31, 2002. Based on the files examined, it appears that the Company is not in compliance with Colorado insurance law in that nine (9) of the files did not contain the required disclosure statement on the applications.

Recommendation No. 10:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-6-5. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all affected small group application materials to include the disclosure required by Colorado insurance law.

Issue G3: Failure to obtain the required employer provided listing of eligible dependents.

Regulation 4-6-8, amended effective November 1, 1997, Concerning Small Employer Health, promulgated under the authority of Sections 10-1-109(1), 10-8-601.5(1)(a)(IV), (1)(c)(I), and (3), 10-16-105(5), 10-16-108.5(8), 10-16-109, 10-16-214 (1)(d), and 10-16-708, C.R.S., states:

Section 5. Issuance of Coverage

B. Determining Who is an Eligible Employee, Dependent

- 3) A small employer carrier shall require each small employer that applies for coverage with an effective date on or after January 1, 1995, as part of the application process, to provide *a complete list of eligible employees and dependents of eligible employees, and a list of employer-determined eligible employees and dependents, if this is a different list.* [Emphases added.] The small employer carrier may require the small employer to provide appropriate supporting documentation (such as a W-2 Summary Wage and Tax Form) to verify the information required under this paragraph.

Small Group Application Sample

Population	Sample Size	Number of Exceptions	Percentage to Sample
4,892	50	50	100%

The examiners reviewed a systematically selected sample of fifty (50) files from a population of 4,892 representing new small group applications received during the exam period of January 1 through December 31, 2002. Based on the files examined, it appears that the Company is not in compliance with Colorado insurance law in that none of the sample files contained a list of eligible dependents. The examiners noted however, that the files did contain a list of eligible employees

Recommendation No. 11:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-6-8. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its procedures to ensure that all small employer groups provide a complete listing of eligible dependents as required by Colorado insurance law.

Issue G4: Failure, in some instances, to include the small group disclosure requirements in new application materials. *(This was prior issue G5 in the findings of the 1999 final examination report.)*

Regulation 4-6-8, amended effective November 1, 1997, Concerning Small Employer Health Plans, promulgated under the authority of Sections 10-1-109(1), 10-8-601.5(1)(a)(IV), (1)(c)(I), and (3), 10-16-105(5), 10-16-108.5(8), 10-16-214(1)(d), and 10-16-708, C.R.S., states:

(9) Disclosure requirements

(A) Pursuant to Sections 10-16-105(5), as amended by Senate Bill 97-54, and 10-16-704(9), C.R.S., small employer carriers shall provide, on all printed marketing and solicitation materials for their small group health products and in a separate boxed section with bold type no less than twelve (12) point, a clearly written disclosure that:

- (1) Identifies the class of business;
- (2) Specifies case characteristics and rating factors used in setting new and renewal rates and the extent to which they impact premiums;
- (3) Explains the employer's right to renew;

Small Group Application Sample			
Population	Sample Size	Number of Exceptions	Percentage to Sample
4,892	50	9	18%

The examiners reviewed a systematically selected sample of fifty (50) files from a population of 4,892 representing new small group applications for coverage received during the period January 1 through December 31, 2002. Based on the files examined, it appears that the Company is not in compliance with Colorado insurance law in that nine (9) of the files did not contain the required Small Employer Health Plan disclosure.

Recommendation No. 12:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-6-8. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its procedures to ensure that all small employer group application materials contain the Small Employer Health Plan disclosure required by Colorado insurance law.

In the Market Conduct examination for the period January 1, 1997 through January 31, 1998, the Company was cited for failure to comply with disclosure requirements concerning setting of new and renewal rates and premium impact. The violation resulted in Recommendation #60, that the Company revise its solicitation materials to include the required disclosure statement. Failure to comply with the previous recommendation and order of the commissioner may constitute a violation of Section 10-1-205, C.R.S.

SUMMARY OF ISSUES AND RECOMMENDATIONS

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E7: Failure of the Company’s forms to provide coverage for congenital defects and birth abnormalities as mandated by Colorado insurance law.	7.	32
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G4: Failure, in some instances, to include the small group disclosure requirements in new application materials. <i>(This was prior issue G5 in the findings of the 1999 final examination report.)</i>	12.	40

State Market Conduct Examiners

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